Request to Amend or Addend Medical Records

Amendment Requests:

An **amendment** is a change made to your medical record by the author who wrote it.

Under **HIPAA 45 CFR § 164.526**: Patients have the right to request an amendment to their medical record. This gives patients the right to ask their provider to amend their Designated Record Set (DRS), which may include striking out information, deleting information, or appending information.

- Providers can comply, partially amend, or deny your request.
- Hoag will respond to amendment requests in writing within 60 days. If additional time is needed, we can extend another 30 days for 'unusual' or 'unexpected' circumstances.

Addendum Requests:

An **addendum** is an addition to your medical record using your own words and preserving the current information in your medical record.

Under **California Health & Safety Code §12311**: Patient has the right to submit a written addendum to their medical record including when patients are unable to amend or remove information, they believe is incorrect.

- Your additional statement must be limited to 250 words or less per alleged incomplete or incorrect item.

To request to amend or addend your medical records, you will need to complete the form REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PS 2049).

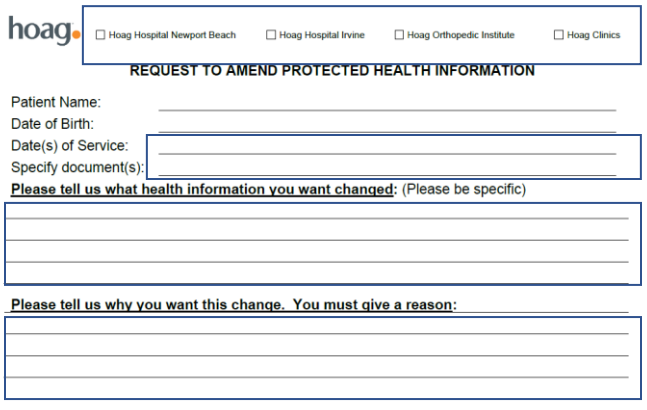
- Make sure to follow the instructions appended to the form.
- Please note that incomplete forms cannot be processed by Hoag's Health Information Department. Please make sure the form is completed in its entirety, otherwise, it will be denied.

Choose which location this request is applicable

List the Date(s) of Service and documents this request is applicable

Be specific about what you want changed

Be specific about what you want changed



hoag.

☐ Hoag Hospital Newport Beach ☐ Hoag Hospital Irvine ☐ Hoag Orthopedic Institute ☐ Hoag Clinics

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Date(s) of Service: _____

Specify document(s): _____

Please tell us what health information you want changed: (Please be specific)

Please tell us why you want this change. You must give a reason:

Hoag Health System

Provide the contact information where we should send the letter and communicate with you.

Provide the contact information, other than yourself, to whom we will be sending the changed information. Make sure to initial.

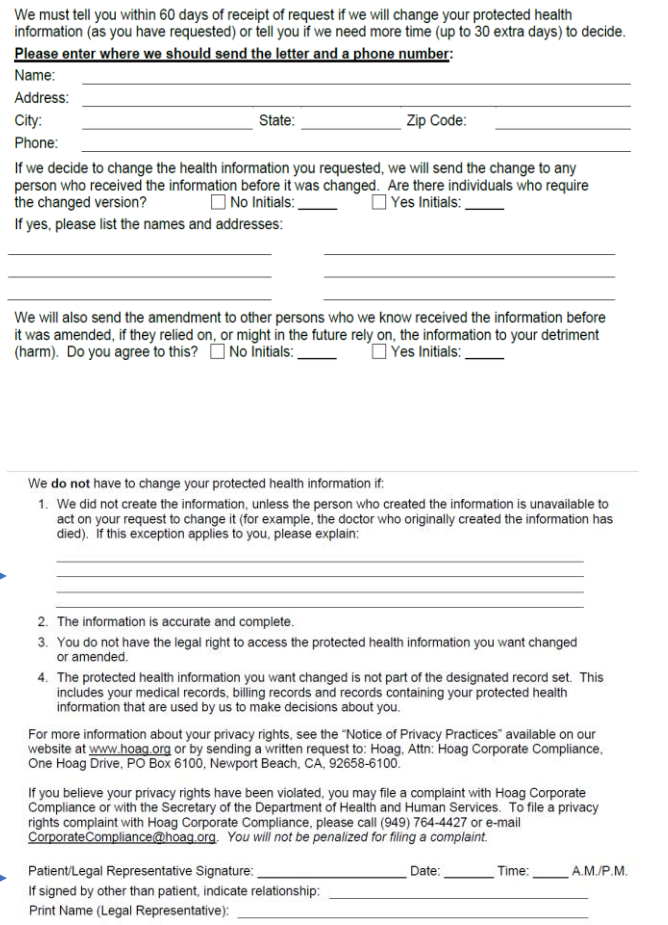
Determine if you want us to send it to other persons who previously received the information before it was changed. Make sure to initial.

Under Federal and State law, these are Hoag's rights as to why your information was not changed. If there is an exception, please explain.

Make sure to sign and provide date/time.

Once you complete the form, return it to us either any of the listed methods:

1. Mail
2. Email
3. In Person



We must tell you within 60 days of receipt of request if we will change your protected health information (as you have requested) or tell you if we need more time (up to 30 extra days) to decide.

Please enter where we should send the letter and a phone number:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

If we decide to change the health information you requested, we will send the change to any person who received the information before it was changed. Are there individuals who require the changed version? ☐ No Initials: ____ ☐ Yes Initials: ____

If yes, please list the names and addresses:

_____ _____

_____ _____

_____ _____

We will also send the amendment to other persons who we know received the information before it was amended, if they relied on, or might in the future rely on, the information to your detriment (harm). Do you agree to this? ☐ No Initials: ____ ☐ Yes Initials: ____

We **do not** have to change your protected health information if:

1. We did not create the information, unless the person who created the information is unavailable to act on your request to change it (for example, the doctor who originally created the information has died). If this exception applies to you, please explain:

   _____

   _____

   _____

   _____

2. The information is accurate and complete.
3. You do not have the legal right to access the protected health information you want changed or amended.
4. The protected health information you want changed is not part of the designated record set. This includes your medical records, billing records and records containing your protected health information that are used by us to make decisions about you.

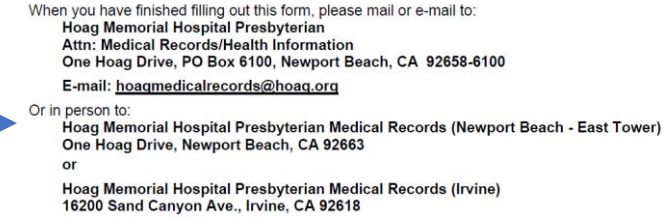
For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at www.hoag.org or by sending a written request to: Hoag, Attn: Hoag Corporate Compliance, One Hoag Drive, PO Box 6100, Newport Beach, CA, 92658-6100.

If you believe your privacy rights have been violated, you may file a complaint with Hoag Corporate Compliance or with the Secretary of the Department of Health and Human Services. To file a privacy rights complaint with Hoag Corporate Compliance, please call (949) 764-4427 or e-mail CorporateCompliance@hoag.org. *You will not be penalized for filing a complaint.*

Patient/Legal Representative Signature: _____ Date: _____ Time: ____ A.M./P.M.

If signed by other than patient, indicate relationship: _____

Print Name (Legal Representative): _____



When you have finished filling out this form, please mail or e-mail to:

Hoag Memorial Hospital Presbyterian
Attn: Medical Records/Health Information
One Hoag Drive, PO Box 6100, Newport Beach, CA 92658-6100

E-mail: hoagmedicalrecords@hoag.org

Or in person to:

Hoag Memorial Hospital Presbyterian Medical Records (Newport Beach - East Tower)
One Hoag Drive, Newport Beach, CA 92663
or

Hoag Memorial Hospital Presbyterian Medical Records (Irvine)
16200 Sand Canyon Ave., Irvine, CA 92618